PLEASE PRINT OR TYPE

KENTUCKY BOARD OF NURSING

VERIFICATION OF SUPERVISION FOR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) APPLICANT

(Please disregard if currently certified by a national organization for advanced nursing practice.)

This form must be completed by your employer or the facility where you will be employed. Please provide the information below, then forward this form to the applicable employer/facility with a letter requesting its completion.

ARNP APPLICANT NAME: _____

PRACTITIONER TYPE: Designated Nurse ☐ Anesthetist ☐ Practitioner ☐ Midwife ☐ Clinical Specialist

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

_____

EMPLOYER'S TELEPHONE #: ( ) _____ **DATE OF EMPLOYMENT:** _____

EMPLOYMENT POSITION: _____

This form verifies that the ARNP applicant listed above will be practicing in accordance with established protocol* and under the onsite supervision** of an advanced registered nurse practitioner of the same specialty area or a licensed physician until the results of the certification examination have been received. **All individuals providing such supervision must sign this form in the spaces provided below.**

* Protocol is defined in 201 Kentucky Administrative Regulation 20:057, ARNP Scope and Standards of Practice (Section 2). An informational copy may be requested from the Board office.

** Supervision is defined in KAR 20:056, Section 4(1)(b) as periodic observation and evaluation of the applicant's practice to validate that the practice has been performed according to established standards. The supervisor shall be immediately available either on site or by telephone.

I hereby agree to provide the required supervision to the above named applicant for ARNP registration:

_____ _____ _____ _____

SIGNATURE OF SUPERVISING ARNP **DATE** **SIGNATURE OF SUPERVISING PHYSICIAN** **DATE**

KY RN LICENSE # _____ **ARNP #** _____ **KY LICENSE #** _____

(Space for additional signatures is provided on the reverse side of verification form if needed.)

Should the ARNP applicant's employer/supervisor(s) change, a new verification of supervision form must be submitted.

THE COMPLETED FORM MUST BE MAILED DIRECTLY BY THE EMPLOYER/FACILITY TO THE ADDRESS BELOW. IF QUESTIONS, CALL EXTENSION 251 AT THE BOARD OFFICE (502-329-7000).

ARNP UNIT
KENTUCKY BOARD OF NURSING
312 WHITTINGTON PKY STE 300
LOUISVILLE KY 40222-5172

5/96 dc

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

Signature of Supervising ARNP | Date | Signature of Supervising Physician | Date

KY RN License # ________ ARNP # ________ KY License # ________

EMPLOYER COMMENTS: